Confidential Medical History

B & R Dental Care

Name		**DOB**	
Address **Post Code**		**Home Tel.**	
Email	< Please tick Email - Mobile box(es) if you received **EMAIL** and / or **SMS reminder** >	**Mobile**	
National **H**ealth **S**ervice No (Not National Insurance Number)		**Doctor's Surgery**	

MEDICAL HISTORY

Please tick all which apply to your medical history.

Heart	Rheumatic Fever		High Blood Pressure		Heart Surgery		Pacemaker Fitted	
	Heart Murmur		Angina		Thrombosis		Other Heart Conditions	

Details:

Chest	Bronchitis		Emphysema		Pneumonia		Chest Surgery	
	Smoker		Cystic Fibrosis		Pleurisy		Other Chest Conditions	

Details:

Blood	Bleeding		Hepatitis B		HIV		Anaemia	
	Regular Blood Test		Sickle Cell		Haemophilia		Other Blood Conditions	

Details:

Other	Serious Child Illness		Diabetes		Liver Disease		Kidney Disease	
	Epilepsy		Cancer		G.A. Experience		Other Conditions	

Details:

Allergies	Penicillin		Hay Fever		Anti Tetanus Serum		Eczema	
	Aspirin		Asthma		Latex Allergy		Other Allergy	

Details:

Warnings	No Local Anaesthetic		Antibiotic Cover		Do Not Recline		Pregnant	
	Warning Card		Artificial Joint		Special Precautions		Due date _____	

Yes	No	Currently **under treatment** of a doctor, hospital or clinic.
Yes	No	Have you experienced any **allergies** or **unusual effects** from any tablets, drugs, injections or anaesthetic?
Yes	No	**Bruising** or persistent **bleeding** after injury, surgery or tooth extraction.
Yes	No	Do you suffer from **Cold Sores**?
Yes	No	Is there anything else that you think that we should know?

Details:

Medication	List and state doses for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) you are taking:

SOCIAL HISTORY

(Please tick or circle all that apply)

How many units of **alcohol** do you drink per week?	0-13	14-20	21+		
Do you **smoke**?	Never	Past	Social	Regular	
What **toothpaste** do you use?					
How many times a day you **brush** your teeth?	0	1	2	3	More
Do you **floss**?	Yes	No			
Are you aware of the Government's **"5 a day"** programme?	Yes	No			
Do you try to achieve this?	Yes	No			

What would you drink, if you are **thirsty**? Water Milk Tea Coffee Fizzy drinks Diet fizzy drinks
Fruit Juice Squash With sugar Without sugar

By signing this form I give permission for any x-rays that may need to be taken. Please tick the box if you **DO NOT** give permission for x-rays. ☐

Signed: Patient/Parent/Guardian Date	
Signed: Dentist Date	

All the information you write on this form is kept safe and confidential. The reason we ask you to fill in this form is so we can treat you safely and provide you with quality dental care. This form will be updated at every visit and changes recorded.